# Special Needs Registry Instructions

1. Please fill out **ALL** questions on form.

2. Check all boxes answering “Yes” or “No”

3. Please fill out **one form Per Household Member with a Special Need**

    **a.** If your home contains more than **ONE** person with special needs please fill out additional forms provided.

4. If your information changes at anytime you will need to provide your updated information, as it is important that the registry be up to date. Call 806-378-3000 and request special need registry personnel to assist you.

5. **The information contained on the forms and in the registry is kept confidential unless you designate otherwise on the registration form that the information can be released.**

6. Mail completed registration form(s) to:
    City of Amarillo Office of Emergency Management
    C/O Medical Preparedness Planner
    P. O. Box 1971
    Amarillo, TX 79105

If you wish to register by phone, call 806-378-3000 and request special needs registry personnel from 9:00am to 4:00pm.

# 2008 SPECIAL NEEDS REGISTRY

**Print clearly or type information and answer questions by checking the appropriate box.**

Today's Date: _____

Do you want this information released to the state's Special Needs Registry? □ Yes □ No

**Head of Household Name:** First:_____ Last:_____

**Special Needs Registrant (must be a street address and not a PO Box):**

Name: First:_____ Last:_____ MI:___ Gender: □ Female □ Male

Street Address:_____ Apt. #:_____ Building #_____

City: _____ County:_____ Zip Code:_____ Phone:(_____)_____

Email: _____ Date of Birth: _____

Who will provide update information? □ Special needs registrant □ Legal guardian □ Emergency contact

**Special needs registrant's emergency contact and/or legal guardian contact information:**

Name: First:_____ Last:_____

Relationship to registrant:_____ Phone :(_____)_____

Is the emergency contact the legal guardian? □ Yes □ No Email : _____

**Questions about the special needs registrant to assist Emergency Management Officials:**

Do you only need assistance with transportation? □ Yes □ No

How many others in the household will evacuate with you? □ None Specify number:_____

Will a caregiver or family member evacuate with you? □ Yes □ No

How many household members have special needs? Specify number:_____

**If more than one, complete an additional household member form for each additional person.**

Do you have a pet(s)? □ Yes □ No If yes, how many?_____

Do you have carriers for every pet? □ Yes □ No If yes, how many?_____

**Medical special needs include but are not limited to one or more of the following: needing assistance during an evacuation and/or sheltering because of a physical or mental condition or the registrant's level of medical care are beyond basic first aid.**

Do you have medical special needs? □ Yes □ No

Is your condition temporary? □ Yes □ No If yes, estimate date of recovery:_____

Do you have a service animal? □ Yes □ No

Do you use oxygen? □ Yes □ No

Are you dependent on others for routine care (eating, walking, toileting, etc.)? □ Yes □ No

Are you under 18 years of age? □ Yes □ No

Are you (check all that apply): □ blind □ hearing impaired □ deaf □ an amputee
□ 350 lbs. or more

Do you have (check all that apply): □ mental health condition □ mental retardation

Do you require assistance with medical care administration, monitoring by a nurse, dependent on equipment or assistance with medications? □ Yes □ No

Do you require extensive medical oversight in your home (i.e., IV chemotherapy, ventilator, peritoneal dialysis, hemodialysis, life support equipment, hospital bed, total care, morbidly obese)? □ Yes □ No

Do you have a current Vial of Life? □ Yes □ No

Do any of the following apply?

□ Are you confined to a bed? □ Do you use a wheelchair? If yes, is it motorized? □ Yes □ No

Do you use any of these types of medical equipment (check all that apply)?

□ cane □ walker □ nebulizer (breathing machine) □ blood sugar monitor

Do you require power for medical equipment? □ Yes □ No

**2008 SPECIAL NEEDS REGISTRY – For Additional Household Member**

**Print clearly or type information and answer questions by checking the appropriate box.**
Today's Date: _____
Do you want this information released to the state's Special Needs Registry? □ Yes □ No

**Head of Household Name:** First:_____ Last:_____

**Special Needs Registrant**

Name: First:_____ Last:_____ MI:___ Gender: □ Female □ Male

Email Address: _____ Date of Birth:_____

Who will provide update information? □ Special needs registrant □ Legal guardian □ Emergency contact

**Special needs registrant's emergency contact and/or legal guardian contact information if different than previous registrant:**

Name: First:_____ Last:_____

Relationship to registrant:_____ Phone Number:(____)_____

Email Address: _____
Is the emergency contact the legal guardian? □ Yes □ No

**Questions about the special needs registrant to assist Emergency Management Officials:**
Do you only need assistance with transportation? □ Yes □ No
Will a caregiver or family member evacuate with you? □ Yes □ No
If more than one, complete an additional household member form for each additional person.

**Medical special needs include but are not limited to one or more of the following: needing assistance during an evacuation and/or sheltering because of a physical or mental condition or the registrant's level of medical care are beyond basic first aid.**
Do you have medical special needs? □ Yes □ No
Is your condition temporary? □ Yes □ No If yes, estimate date of recovery:_____
Do you have a service animal? □ Yes □ No
Do you use oxygen? □ Yes □ No
Are you dependent on others for routine care (eating, walking, toileting, etc.)? □ Yes □ No
Are you under 18 years of age? □ Yes □ No
Are you (check all that apply): □ blind □ hearing impaired □ deaf □ an amputee
□ 350 lbs. or more
Do you have (check all that apply): □ mental health condition □ mental retardation
Do you require assistance with medical care administration, monitoring by a nurse, dependent on equipment or assistance with medications? □ Yes □ No
Do you require extensive medical oversight in your home (i.e., IV chemotherapy, ventilator, peritoneal dialysis, hemodialysis, life support equipment, hospital bed, total care, morbidly obese)? □ Yes □ No
Do you have a current Vial of Life? □ Yes □ No
Do any of the following apply?
Are you confined to a bed? □ Yes □ No
Do you use a wheelchair? □ Yes □ No If yes, is it motorized? □ Yes □ No
Do you use any of these types of medical equipment (check all that apply)?
□ cane □ walker □ nebulizer (breathing machine) □ blood sugar monitor
Do you require power for medical equipment? □ Yes □ No